Membership Registration Form 2017

Please complete and return application form. Assistance to complete is available. Section A must be completed by all members. Section B is for completion by those with children attending activities in the over 12 age bracket who will not have a parent or guardian present

Section A – All members to complete

Parent/Guardian's name:		
Address		
Phone:	**Mobile**	**Email**
Preferred method to receive updates and be contacted :		

Details of Children in the family

Name	DOB	ASD	Other associated conditions ie ADHD
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

Alternative contact person*(in case of emergency and you are not available):*	
Please state relationship to young person:	
Address:	
Mobile phone:	**Home phone:**

Medical Details **Doctor's name:**
Doctor's Address:
Phone:
Any known allergies or medical conditions (include the child's name relevant to):

Is your child on prescribed medication. If so please list meds and name of child relevant to

_____

_____

_____

Please indicate what you would like support with

Information and Signposting ☐ Information / Education Seminars ☐

Social Opportunities for both You and children ☐ Peer Parent Support ☐

Other:_____

Please include suggestions for activities / supports you would like to see the organisation provide

_____

_____

_____

Do you give the Autism Family Support Group permission to take photographs of you and your family during events and activities? These will be used for social media and to promote the organisation etc Yes ☐ No ☐

I confirm that I have read the organisation's membership policy and understand my role as a member of the Autism Family Support Group CLG Yes ☐ No ☐

I confirm that the information given is correct and up to date information. All information will be treated on the strictest of confidence and only shared with those whose role entitles them to see such information.

Signed: _____ Date: _____

Parent/ Guardian

Section B – For members with children over 12 unaccompanied by a parent or Guardian

This section must be completed by the parent or guardian of a child over 12 who will attend activities without an accompanying adult. This is to allow us fully understand the needs of the young person and inform the youth leader of how to best support them. If you are unable to complete this section as much as it is practical then you will be required to attend all activities with your child if they are to avail of the activity.
Name of child 12 or over

_____

Does your child have any sensory issues?

☐ Yes ☐ No

(if yes, please provide full details)

_____

_____

_____

Does your child have any difficulties communicating?

☐ Yes ☐ No

(if yes, please provide full details)

_____

_____

_____

Does your child require assistance with dressing etc? ☐ Yes ☐ No
For child protection reasons we are unable to provide assistance in this area and will require the carer to be present

Does your child/young person have any behavioural triggers / fears that we should be aware of?

☐ Yes ☐ No

(if yes, please provide full details)

_____

_____

_____

What activities does your child/young person **like** to do?
This will enable us to plan a varied programme suiting the interests and ability of everyone

_____

_____

_____

Is there anything in particular that they do not wish to take part in?

_____

_____

_____

In the eventually that my child / young person requires medical treatment and myself and my named contacts are unavailable, I authorise a member of the Autism Family Support Group leader in charge to consent to my child/young person to be seen by a doctor.

☐ Yes ☐ No

I confirm that the above information is accurate to the best of knowledge

Signed:_____ Date: _____

If you intend to be present for all activities with your son or daughter aged 12 and over please sign the following declaration

I _____ will be present for all events or activities in respect of my son or daughter named _____
Date: _____